

Georgia Health Information Exchange

Business, government and healthcare working together for better health outcomes and value

GHIE Environmental Scan Executive Summary

GHIE member associations conducted an environmental scan to identify contributions that stakeholders in Georgia are making in the field of physician practice electronic clinical information production and use or pay-for-performance. This is a summary of a Draft report. This in no way encompasses all initiatives in the state. Only programs that were active at the time of the survey were included.

The following stakeholders were included in this environmental scan:

- Hospitals
- Employers
- Commercial Health Plans
- Physicians
- Multi-stakeholder Health Care Policy/Quality Coalitions

The following is a summary of results from each stakeholder group:

Hospitals (page 2-8)

Electronic initiatives in hospitals suggest a significant level of functional sophistication and a somewhat lower level of technological sophistication, and even lower levels of integration sophistication. In general, urban hospitals have higher IT sophistication than rural hospitals for all three domains. This trend is also seen in large hospitals versus small hospitals. At the time of the survey, 82% of Georgia hospitals have or are planning to implement a Computerized Physician Order Entry (CPOE) system. However, full functionality seems to be a few years away. Many hospitals are in various levels of implementation of Bar Coding systems.

Employers (page 9-12)

As of publication of this report, most major employers in Georgia have been slow in moving to pay-for-performance programs. There seems to be considerable discussion regarding the process to implement pay-for-performance. Some major employers in Georgia are participating in the Bridges to Excellence (BTE) program. Employers involved in this effort believe that by finding and rewarding physicians who practice highly effective care and by engaging consumers and implementation of specific processes and information systems that have been shown to reduce errors and increase quality. Currently, the BTE program targets three areas: high-quality cardiovascular care, high-quality diabetes care, and physician offices that have efficient and effective systems of care.

Commercial Health Plans (page 12-18)

This review of the largest commercial payers with managed care plans suggests that movement in electronic medical records and pay-for-performance is in its infancy in Georgia. Several Georgia plans are reviewing options and developing initiatives to encourage physicians to move forward with electronic medical records. However, the levels of discussion and interest would suggest that progress could occur in the near term, particularly with outside pressures. Many commercial payers are undertaking individual electronic initiatives.

Physicians (page 18-21)

Based on a recent membership survey by the Medical Association of Georgia, it is estimated that 5% of physicians have some form of electronic medical record system and over half have a practice management system. MAG has not conducted any program that promotes the adoption of electronic clinical information system, but is developing a strategy for such an effort. The Georgia Academy of Family Physicians has endorsed an EMR vendor. The Georgia Association of Primary Health Care as a project that will install EMRs at 13 member sites and train all clinical staff on tracking and reporting capabilities.

Multi-stakeholder Health Care Policy/Quality Coalitions (page 21-26)

In addition to the Georgia Health Information Exchange, there are a number of coalitions in the state that are focusing on ways that technology or pay-for-performance could positively impact Georgia healthcare. Some groups include:

- Georgia Healthcare Leadership Council
- Savannah Business Group
- Center for Health Transformation
- SharpWorkGroup (and related initiatives)
- Tri-County Plus Rural Health Network
- West Georgia Health Information Exchange
- Georgia Pharmacy Association

Environmental Scan

GHIE member associations conducted an environmental scan to identify contributions that stakeholders in Georgia are making in the field of physician practice electronic clinical information production and use or pay-for-performance. In our environmental scan, we surveyed hospitals and healthcare networks, major employers, commercial health plans, physicians and medical specialty organizations, and multi-stakeholder health care policy/quality coalitions.

In this environmental scan, we include the following major categories of stakeholders:

- A. Hospitals;
- A. Employers;
- B. Commercial Health Plans;
- C. Physicians; and
- D. Multi-stakeholder Health Care Policy/Quality Coalitions.

Overview of Georgia

Georgia has a population of over 8, 684,715 citizens. Within this population, 65.1 % are White, 28.7% are Black or African-American and 5.3% are Hispanic/Latino.

Over two (2) million Georgia citizens receive their healthcare provided by the Georgia Department of Community Health which includes Medicaid, PeachCare For Kids and the State Health Benefit Plan. An additional one million Georgia citizens are covered by Medicare. The majority of other insured citizens, approximately 4.2 million, are employed and most receive their healthcare through employer-sponsored programs of various types. The remaining approximately 1.4 million Georgians have no health coverage.

In Georgia, there are over 202,505 private, non-farming employers. The 2001 Georgia census lists over 3, 498,583 citizens employed by businesses. The leading industries in Georgia are education, health and social services, which comprise 18% of the industries and manufacturing which comprises 14%.

There are 159 counties in Georgia. Georgia's largest cities are: Atlanta, Augusta, Columbus, Savannah, Macon and Albany. All of these cities maintain active business coalitions.

A. Hospitals

There are approximately 170 hospitals throughout Georgia, 70 are JCAHO accredited. For the largest state east of the Mississippi River, it is not a surprise that these hospitals range in size from 15 to 637 beds. Georgia's largest facility employs over 5,000 staff. For purposes of Medicare payment, there are 110 designated short-term acute care facilities, 15 long term care acute, and 32 recently created critical access hospitals. The 2005 GHA Membership Directory lists thirty-three health systems which range in size from 1 to 12 hospitals. Over half of Georgia's community hospitals are defined as "urban" by Medicare. Nineteen of Georgia's community hospitals are investor-owned, fifty-eight are associated with hospital authorities, and the remainder are not-for-profit.

An important organization in the Georgia hospital landscape is the Partnership for Health and Accountability (PHA), which is the member driven voluntary, statewide, patient safety organization of the Georgia Hospital Association. All 150 acute care hospitals in

Georgia participate in PHA. Under the guidance of PHA's Accountability and Health Safety Committee and the Best Practices Committee, Georgia hospitals have shown a significant improvement in their processes and clinical performance. Notably, another GHIE stakeholder, the Georgia Medical Care Foundation (*gmcf*) has been a long time partner with this program and will continue to work collaboratively to promote practices and technology that will improve quality and safety in the patient care provided in Georgia.

Based on contacts with hospitals and an extensive statewide IT survey, most Georgia hospitals are in the planning and development stages with Computerized Physician Order Entry (CPOE). A summary of the findings (later in this section) from the statewide hospital survey provides an snapshot of the progress of Georgia hospitals. Specific information is presented for three hospital systems: Emory HealthCare, Medical College of Georgia Health System, and three west Georgia hospitals.

Those hospital systems that are reportedly further along the CPOE path include Promina hospitals (Piedmont, Southern Regional, and Gwinnett), Wellstar System hospitals, and HCA hospitals and Medical College of Georgia. Other facilities recognized as being progressive in this arena include Medical College of Georgia Health System, and Medical Center of Central Georgia. A follow-up survey is planned in collaboration with Georgia Hospital Association to obtain additional information.

Emory HealthCare

According to the director of the Electronic Medical Records project at Emory Healthcare, which encompasses several hospitals and multi-specialty clinics, Emory Healthcare is in the midst of a multi-phase initiative moving toward Computerized Physician Order Entry. Their perception is that the Academic Medical Centers (AMCs) are ahead of many of the other hospital systems with electronic systems/CPOE.

For Emory Healthcare, the first phase was developing a master patient index, so that links could be established for information throughout the system. Currently, the second phase is linking various services, such as interfaces with radiology, lab and pharmacy. Emory Healthcare uses the PowerChart system for their order management. Emory Healthcare has used PowerChart for many years, mainly as a repository for lab and some pharmacy. It is estimated that 15% of the paper chart is now electronic.

At this time, all orders are still via paper by physicians. A nurse or aide enters the orders into the system. There is a plan to pilot direct input by physicians, although they are not ready to eliminate paper orders from a legal and systems perspective. It is estimated that it will be at least two years before CPOE is fully implemented at Emory Healthcare. Before full implementation, the plan is be able to prompt physicians with alerts and to have all vital signs and prescription history available.

Piedmont Hospital

Piedmont Hospital is among the best hospitals in the nation when it comes to embracing the information age. Piedmont was named one of the 100 Most Wired U.S. hospitals in the "2004 Most Wired Survey and Benchmarking Study". Piedmont was one of nearly 1,300 hospitals and healthcare systems that participated in the 2004 survey. The annual

survey, in its sixth year, was conducted by Hospitals & Health Networks -- the journal of the American Hospital Association (AHA) -- in collaboration with IDX Systems Corporation and the College of Healthcare Information Management Executives (CHIME).

In 2003, Piedmont Hospital launched "QUEST (Quality, Uniformity, Efficiency, Safety and Technology) for Better Patient Care" program. Under this initiative, clinical reports such as lab reports and X-ray results can be electronically stored and accessed. Physicians and clinicians can access reports securely from the hospital, office or from home.

New systems allow Piedmont physicians and clinicians to enter test, medication and procedure orders directly into a computer (CPOE or computer provider order entry). This technology will decrease the number of errors due to illegible handwriting, speed up the ordering process and generate alerts when conflicts between a doctor's order and the patient's medical background are detected.

"These hospitals realize the power of the electronic medical record to improve quality, safety and the patient experience," said Alden Solovy, executive editor of Hospitals & Health Networks. Note, as a result of a tie, 101 hospitals were named on this year's 100 Most Wired list.

Georgia Hospitals IT Survey

In the fall of 2003, the GHA's Partnership for Health and Accountability collaborated with a researcher at the Rollins School of Public Health at Emory University (Emory) to survey Georgia hospitals concerning their plans and progress with respect to Computerized Physician Order Entry (CPOE) and IT infrastructure. These organizations, GHA and Emory, have agreed to share highlights and summary data from this extensive hospital survey with GHIE. Because of confidentiality pledges and publication rights, the names of facilities and additional detail cannot be used at this time. However, GHA and Emory have agreed to collaborate on an update of this survey in the near future, and permission would be requested from hospitals to release identities for the update information. It was agreed that this information would be helpful to all parties.

The following summaries and statistics are highlights and excerpts from an unpublished report by Steven D. Culler, Ph.D., Associate Professor, The Rollins School of Public Health at Emory University. Permission was obtained from Dr. Culler and GHA for release of this information.

More than half of all hospitals in Georgia responded to this survey. Overall, 75 of the 142 hospitals returned completed surveys, yielding a completion rate of approximately 53 percent. The distribution of survey respondents was representative of both the geographic and bed-size distribution of all Georgia hospitals. Respondents were 63% from urban hospitals and 37% from rural hospitals. In terms of bed size, respondents had the following distribution: under 50 beds – 28%; 50 to 99 beds – 17.3%; 100 to 299 beds – 37.3% and over 300 beds – 17.3%.

The two primary goals of the survey included:

- To identify how many hospitals have implemented or are planning to implement a CPOE system
- To assess current IT infrastructure for all hospitals in Georgia across three domains
 - Functional sophistication
 - Technological sophistication
 - IT integration

Status of CPOE Systems in Georgia Hospitals

One of the purposes of the CPOE and IT Infrastructure Survey was to determine the extent that Georgia hospitals had implemented or were planning to implement CPOE systems. The survey results indicate that 13% of all Georgia hospital survey respondents currently have CPOE systems, and an additional 69.4% of the respondents are planning to implement a CPOE system. However, 17.3% of the hospitals surveyed indicated that they have no plans to implement a CPOE system. A greater percentage of urban hospitals indicated they currently have or are planning to implement a CPOE system than rural hospital respondents, 93.4% versus 64.3%, respectively. In addition, all hospitals with more than 100 beds responding to the survey indicate they currently have or are planning to implement a CPOE system, while this was true of only slightly more than half of the hospitals with fewer than 50 beds. Finally, in comparing the proportion of hospitals that currently have CPOE systems, there is less difference between urban and rural hospitals (14.9% and 10.7%) than between large and small hospitals. The proportion that have CPOE systems varies from a low of 4.8% for hospitals with fewer than 50 beds to a high of 23.1% for both hospitals with 50 to 99 beds and those with more than 300 beds.

Operational Status of Inpatient and Outpatient CPOE Systems

Of the 62 hospitals that indicated that they currently have or are planning to implement CPOE systems, only 3 Georgia hospitals currently have an operational inpatient or outpatient CPOE system. However, the number of hospitals with operational inpatient CPOE systems is expected to increase rapidly in the next two years, as 20 of the 62 hospitals expect their inpatient system to be operational within two years. Conversely, only 12 of the 62 hospitals expect their outpatient CPOE system to be operational in the next two years. Two of the three hospitals that indicate they currently have an operational CPOE system are located in rural areas in hospitals with fewer than 100 beds, but only 3 of the remaining 19 survey respondents with fewer than 100 beds expect to have an operational inpatient CPOE system in the next two years.

Physician Utilization of CPOE Systems

At the two extremes, 18.3% of all hospitals responding indicate the CPOE systems will be optional for all physicians, while 20% of the hospitals indicate they will require all physicians to use the CPOE system. Of the remaining hospitals, slightly more than one-third expect less than half of the physicians to be required to use the CPOE system and the remaining 23% of the hospitals expect to require more than half, but not all, of their physicians to use the CPOE system. There seems to be no consistent pattern to hospitals' plans for requiring physicians to use their CPOE system. For example, more urban (21.4%) than rural (16.7%) hospitals plan to require 100% of their physicians to use their CPOE system, while more rural (27.8%) than urban (7.1%) expect to require between

one-half and three-quarters of their physicians to use the system. Likewise, 80% of the smallest (less than 50 beds) hospitals and more than 50% of the largest (more than 300 beds) hospitals are planning to require more than one-half of all physicians to use their CPOE system.

Hospital IT Infrastructure

The Georgia Hospital IT Infrastructure Survey evaluates hospitals' IT sophistication on three dimensions:

- Functional Sophistication – the number and diversity of processes or activities involving the use of computer-based applications;
- Technological Sophistication – diversity of hardware devices used by health care institutions; and
- IT Integration – degree of internal and external integration of computer-based applications through either common database or electronic links.

Overview of Functional Sophistication – Average Number of Functional Activities

Survey respondents had, on average, 6.5 of the possible 8 computerized patient management activities; 13.4 of the possible 27 computerized patient care activities; and 15.9 of the possible 21 computerized clinical support activities. Among the sub-domains, survey respondents have the highest average level of functional sophistication in pharmacy and the lowest average level of sophistication in nursing. Urban hospitals have more computerized activities available than rural hospitals. Likewise, hospitals with 300 or more beds report having more computerized activities than smaller hospitals for all sub-domains, except for the physicians and nursing sub-domains, where hospitals with between 100 and 300 beds have the most computerized activities available.

Functional Sophistication: Selected Patient Management Activities: For all survey respondents, 100% of the hospitals in Georgia have computerized inpatient admission. Overall, more than 75% of all survey respondents indicated that they have each of the patient management activities available, except for waiting list management, which was computerized in only 16% of the hospitals responding. In general, for any given patient management activity, urban hospitals and the largest hospitals (more than 100 beds) were more likely to be computerized.

Functional Sophistication: Selected Patient Care Activities: On average, hospitals responding to the survey have exactly one-half of the possible patient care activities computerized. However, more than 65% of the survey respondents indicated that they have all five of the physician activities computerized. On the other hand, less than 50% of the survey respondents indicated they have computerized 8 of the 10 nursing activities and 3 of the 5 surgery/operating room activities. The general pattern that a higher percentage of urban and large hospitals, compared to rural and small hospitals, have each patient care activity computerized holds for most, but not all, of the 27 patient care activities.

Functional Sophistication: Selected Clinical Support Activities: The specific clinical support activities are listed under three clinical support sub-domains: laboratory activities, radiology activities, and pharmacy. On average, hospitals responding to the survey indicated that they have computerized 76% of the possible clinical support care activities. Among the clinical support sub-domains, survey respondents have

computerized 81% of the 9 pharmacy activities, 76% of the 8 laboratory activities, and 62% of the 4 radiology activities. In addition, on average, a higher percentage of urban compared to rural hospitals have computerized each of the 21 clinical support activities, except for medication administration in the pharmacy sub-domain. Likewise, the survey results indicate that hospitals with more than 300 beds have computerized 90% of the possible 21 clinical support care activities compared to less than 75% for hospitals with fewer than 100 beds.

Overview of Technological Sophistication

Technological sophistication measures the diversity of hardware devices used by hospitals in the patient management, patient care, and clinical support domains. Overall, survey respondents indicated that they use approximately 55% of the 41 technological devices. On average, urban hospitals indicated that they use more technological devices than rural hospitals, 24.9 versus 18.4, and hospitals with more than 100 beds reported using at least 65% of the technological devices compared to hospitals with fewer than 50 beds who only use 36% (14.8) of the devices surveyed. Among the three clinical domains, the average survey respondent reported using 9.6 of the 15 devices in the area of clinical support, and 11.2 of the 22 devices in all patient care categories, but only 1.7 of the 4 devices in patient management. Emergency room and laboratories were the only two sub-domains where survey respondents indicated they use more than 65% of the devices evaluated, while survey respondents indicated that they use less than 50% of the devices in three sub-domains (physicians, surgery/operating room, and pharmacy). The average number of devices available drops substantially in each of the smaller two bed-size categories.

Technological Sophistication: Selected Patient Management Activities: The percentage of survey respondents using specific patient management technological activities ranges from a low of 27% (scanning of medical records to make them available online) to a high of 53% (bar coding of patients' wristbands and centralized scheduling systems for different outpatient clinics). The percentage of urban hospitals using each of the specific patient management technological activities was higher than the percentage of rural hospitals. In addition, the proportion of hospitals using each specific patient management technological activity was greater as the bed-size category increased, except for using bar coding to track medical records throughout the hospitals.

Technological Sophistication: Selected Patient Care Activities: For all hospitals responding to the survey, there is significant variability in the percentage of hospitals that use specific patient care technological activities, especially in the physician and surgery/operating room sub-domains. For example, 91% of the hospitals have a dictation system for transcribing physicians' notes into medical records, and 88% have a dictation system for post-operative reports. However, only 4% of the hospitals have expert systems that patients use to enter their personal medical history by answering a set of questions, and only 9% of the hospitals have touch-screen systems for notes transcription during operations.

Overall, most of the specific technological activities are used by a greater number of urban hospitals than rural hospitals except for dictation systems for transcribing physicians' notes into medical records and for post-operative notes. An examination of the use of patient care technological activities by bed size reveals two trends. First, there

are only modest differences between the two largest bed-size categories in the percentage of survey respondents that report using each of the patient care technological activities. Second, the percentage of hospitals using specific patient care technological activities varied significantly across items in the smallest bed-size category.

Technological Sophistication: Selected Clinical Support Activities: For all hospitals responding to the survey, there is much greater and more consistent use of technological activities in the clinical support domain than either the patient management or patient care domains. There are only 2 of the 15 specific clinical support activities where less than 50% of the survey respondents indicated that they did not use a specific activity. These items were 1) voice recognition system for results transcription (31%) and 2) electronic requisitions for medications from locations outside the hospital (17%). A greater percentage of urban hospitals than rural hospitals reported using every one of the 15 specific clinical support activities, except for electronic requisitions for medications from locations outside the hospital (18% rural versus 17% urban). The pattern of technological activities by bed size for clinical support activities was similar to that reported for patient care activities, that is, a greater proportion of the largest hospitals use each activity than the smaller hospitals. However, for the clinical support activities, there appears to be much less difference in the percentage of small hospitals versus large hospitals using each activity.

Integration (Degree of Internal and External Integration)

Integration is the interface that links information on multiple computers or computer systems through either a common database or electronic links. Overall, Georgia hospitals reported being integrated for 10.8 of the 16 (67.5%) specific integrating activities in the IT Infrastructure Survey. Survey respondents reported being integrated in 1.7 out of 2.0 (85%) activities in the patient management domain, 5.2 out of 8 (65%) of the activities in the patient care domain, and 4 of the 6 (66.6%) of the activities in the clinical support domain. Urban hospitals reported being integrated in approximately 2.4 more activities, on average, than the rural hospitals, 11.7 versus 9.3 respectively. There is very little difference in the average number of integrated activities by hospital bed size, except for hospitals having fewer than 50 beds. These hospitals reported being integrated for only 7 activities, on average, compared to more than 11 activities for hospitals in the other three bed-size categories.

Integration Sophistication: Selected Patient Management Activities: More than 80% of all survey respondents reported being integrated for the two patient management activities. The general pattern of IT sophistication continues for IT integration activities by hospital characteristic. A greater percentage of urban versus rural hospitals report having integrated patient management activities and the percentage of hospitals being integrated increases with bed size from the smallest to the largest category.

Integration Sophistication: Selected Patient Care Activities: On average, 65% of survey respondents indicate that they are integrated for the 8 specific patient care activities. The percentage of respondents integrated to other computerized systems in their own hospital varies from a high of 80% for patient care systems in the physician sub-domain to a low of 56% of operating room systems. However, a much smaller percentage of survey respondents (49%) indicate that their hospitals' patient care systems are able to interface with external entities' computerized systems. In addition, only 59% of survey

respondents indicate that their nursing information systems are integrated to each other in their own hospital.

Integration Sophistication: Selected Clinical Support Activities: Overall, a greater proportion (80%) of survey respondents indicated that their laboratory systems are integrated with other computerized systems than the proportion that have integrated their radiology activities (66%) or pharmacy activities (71%). As with patient care activities, a significantly smaller percentage of survey respondents indicated that their systems for the three clinical support sub-domains could interface with external entities' systems. Urban hospitals indicated higher levels of integration among the three clinical support sub-domains than rural hospitals, both internally and externally. However, the difference between the percentage of urban and rural hospitals indicating that they have integrated their computer systems is smaller for the pharmacy sub-domain. A smaller percentage of the largest hospitals (300+ beds) have integrated their clinical support activities with external parties than for hospitals in the other bed-size categories. For example, only 31% of the hospitals with more than 300 beds indicated that their pharmacy system could interface with external entities' systems, compared to 71%, 46%, and 33% of hospitals in the other three bed-size categories.

In summary, the results suggest a high to moderate level of functional sophistication and a somewhat lower level of technological sophistication, and even lower levels of integration sophistication in Georgia hospitals. In general, urban hospitals have higher IT sophistication than rural hospitals for all three domains. In addition, the overall level of IT sophistication across all three domains tends to be greatest in the largest hospitals and lowest in the smallest hospitals. Finally, this survey finds that more than 82% of Georgia hospitals have or are planning to implement a CPOE system. However, the vast majority of these CPOE systems will not be operational for several years.

GHA also provided information that more hospitals are implementing and planning to implement Bar Coding due to ease of implementation and lower costs than EMR. It also prevents more errors during administration where there is lower detectability so errors are less likely to be caught. Prescribing errors can be picked up during transcribing, dispensing, and administration by the nurses and pharmacists. Future surveys will query hospitals about their use of bar coding.

B. Employers

In Georgia, there are over two-hundred and two thousand employers with a workforce of almost 4 million employees. About 85% of those jobs are in 14 metropolitan areas throughout the State.

According to the Georgia LaborMarket Explorer, there are six employers in Georgia with over 10,000. There are approximately 100 companies with more than 1000 employees. Each of Georgia's six MSAs has companies of 1000 or more.

For this environmental scan, we contacted four employers that have a significant presence throughout the entire state and provide healthcare benefits to employees in all areas of Georgia. Three of those employers are leaders in the health benefits arena and are moving their companies toward pay-for-performance in other states.

In general, major employers in Georgia have been slow in moving into pay-for-performance programs. However, there seems to be considerable discussion among benefit managers concerning next steps. From discussions and interviews with business health groups and key employer leaders, it seems that several of the largest Georgia-based companies including *Delta Airlines*, *The Coca-Cola Company*, and *Home Depot* have not yet moved forward with pay-for-performance initiatives. The most significant initiative seems to be a recent program of the Savannah Business Group on Health, which will be described in more detail.

Nationally, some Georgia employers are involved with Bridges to Excellence® (BTE) program, an effort that was launched in 2003, in large part by employers. Employers with a Georgia presence include *UPS*, *Verizon*, *GE*, *Proctor and Gamble*, *Humana*, *IBM* and *United Healthcare*. Employers involved in this effort believe that by finding and rewarding physicians who practice highly effective care and by engaging consumers, they can transform the market. Physicians are recognized according to evidence-based measures of quality developed by the National Committee for Quality Assurance (NCQA), with groups including the American Diabetes Association and the American Heart Association/American Stroke Association, as well as physician experts.

Currently, the BTE program targets three areas: high-quality cardiovascular care, high-quality diabetes care, and physician offices that have efficient and effective systems of care. BTE began in 2003, focused on diabetes care in Louisville and Cincinnati. Boston and upstate New York were added later, with more markets planned for 2005. Physicians who are recognized for high-quality diabetes care receive up to \$100 for each patient covered by a participating employer and plan, while those who are recognized for cardiac care earn up to \$160 per patient. The Physician Office Link program distributes bonuses of up to \$50 per covered patient based on an office's implementation of specific processes and information systems that have been shown to reduce errors and increase quality.

According to Dale Whitney, *UPS* executive and leader in the Bridges to Excellence Program, Georgia employers have been slow to move with Pay for Performance programs. Mr. Whitney noted there are 30 communities around the country developing pilot pay-for-performance programs, although there are not currently any in Georgia. Mr. Whitney favors employers paying more for physicians that adopt EMR and meet quality indicators. Providers should be involved in the planning of appropriate indicators. As an example, Bridges to Excellence Program is working with American Diabetes Association in developing their Diabetes Recognition Program.

Many large employers indicate that they are studying the data and considering their options. A benefits source noted that *Home Depot*, which is headquartered in Georgia, is reviewing clinical data and financial data to determine if paying a premium for high quality networks is a cost-effective investment. Other companies are also reportedly reviewing selection criteria, electronic records availability and the bottom line return on investment. The Georgia Health Care Leadership Council is interested in collaborating with efforts to encourage physicians to incorporate EMR into their practices.

Georgia Pacific

Georgia Pacific (GP), an Atlanta-headquartered company, has approximately 8,000 employees throughout the state of Georgia. GP would prefer not to reward quality, based on the same premise that they use for their own company-to produce high quality goods and have a safe environment for their employees. GP believes that they should not have to reward physicians for being quality providers. GP is more interested in identifying quality health care providers and selecting those providers as preferred providers than rewarding certain providers.

GP is working with a company called Core Solutions to develop a predictive modeling methodology for physician profiling. Core Solutions is assisting in “knitting together” various data sources and claims record systems. The result is individual employee/beneficiary profiles. GP is piloting their process in smaller communities, starting in Arkansas. In a small community in Arkansas with a GP manufacturing plant, network physicians can assess online the complete medical/claims profile of each covered employee and their families. For example, the physician can check to determine if the patient has filled their prescription or if the patient has seen other health care providers. The employer’s electronic health record becomes a tool for the physician.

In some markets, health care plans are offering high performance networks at a premium. GP and others are evaluating those networks carefully to determine if the premium is worth the price.

UPS

Dale Whitney, corporate health and welfare manager for Georgia-based *UPS*, is a Leapfrog member and a leader in the national Bridges to Excellence Program. His company provides health coverage to 340,000 employees and another 410,000 dependents and retirees. Whitney says organized resistance by hospital associations has lessened, and that many hospital CEOs are beginning to get the message that employers are serious about effecting change.

While incentive dollars help gain physicians’ attention, Whitney said, *UPS* and the other employers involved also understand the need to engage employees in the program. Simply handing out bonuses to doctors might improve care on a limited scale, but the system will change only if consumers choose recognized physicians who participate in their care programs.

Some companies, including *UPS*, offer co-pay differentials for patients who see NCQA-recognized physicians. But such incentives are not a program requirement, Whitney said. As important as patient incentives can be, an effective communication program that stresses the importance of choosing effective and efficient doctors and hospitals is critical to success. “Consumers must understand and believe that their choices make a difference before they will choose quality,” Whitney said.

UPS, for instance, launched a five-year communication effort to prepare employees and their families to become engaged consumers rather than passive recipients of health care. The program shares independent, unbiased research studies and practical tips on how to get the best care. Navigating the health care system without information can be scary, Whitney said.

As for encouraging physician involvement, Whitney said the financial rewards were designed to ensure that incentives meet the needs of physicians as well as employers and patients. “Early on we learned from our physician advisors that if we wanted our patients to receive care from doctors who provide the evidence-based procedures shown to produce the best outcomes, we would need to pay them appropriately,” he said.

Whitney also agreed that the key to the program’s success lies in its expansion to other locations — and he believes that growth can best be achieved through such efforts as a first-of-its-kind partnership with UnitedHealthcare, which maintains the nation’s largest network of health care providers, with 617,000 physicians and nearly 4,000 hospitals. With UnitedHealthcare as a partner and the group’s first health plan licensee, there is an increased opportunity for the BTE message to reach a wider audience as physicians are encouraged to apply for NCQA recognition, thus becoming eligible for the rewards if they are located in a BTE market.

Georgia Power

Georgia Power, a subsidiary of Southern Company, has a workforce of about 8,800 employees in the state of Georgia. *Georgia Power* has not taken any actions regarding pay-for-performance or providing any incentives to provider groups. However, they have indicated that is on their radar screens. The earliest time frame anything of this nature might be implemented would be 2007.

Verizon

According to Mr. Astuto (Regional Healthcare Manager, also Chairman of Georgia Health Care Leadership Council and his company is a member of Bridges to Excellence), very little progress has been made in moving toward delivering health care excellence in Georgia. Health insurers and health plans have moved too slowly. And the health care providers are not taking the issues seriously. Mr. Astuto stated, “We need to move toward electronically aided and integrated information to improve the provision of care.” The small steps are not fully developed and do not have enough rigor to move health care performance out of the mediocre arena.

Verizon is involved as a participating employer in the Bridges to Excellence program in Massachusetts and upstate New York. Both communities are involved in pay-for-performance for physicians treating patients with diabetes and cardiac conditions. Mr. Astuto is disappointed in the generally poor performance of health care providers in the ongoing treatment of their diabetes patients.

In Florida, where *Verizon* has 50,000 members, quality health care providers are being identified (those that meet criteria). The result is that the quality health care providers stay in the network and other physicians not meeting criteria are then out-of-network. Covered members can still go to those providers, but it costs them more out-of-pocket.

C. Commercial Health Plans

A broad array of health insurers offer health insurance products in Georgia. However, those insurers of relevance to our environmental scan of electronic medical records and pay-for-performance can be linked to those insurers with managed care plans. There are

eleven (11) health plans in Georgia that operate health maintenance organizations (HMOs).

Other than the Georgia Department of Community Health (DCH) which operates the Medicaid, PeachCare for Kids and the State Health Benefit Plan, BlueCross & BlueShield of Georgia (BCBSGA) has the highest market-share with over 3.2 million members in Georgia. BCBSGA provides Medicare supplemental benefits to over 54,000 Georgia seniors. In addition, BCBSGA serves over 930,000 beneficiaries in Georgia at over 1300 hospitals and other healthcare facilities. They process more than 3.6 million Medicare Part A claims per year.

The next four health plans, in size, include Kaiser Foundation Health Plan of Georgia, Aetna Health, United Healthcare of Georgia and Cigna Healthcare of Georgia. Managed care plans which serve smaller market shares in Georgia include: Coventry Healthcare of Georgia, Humana Employers Health Plan of Georgia, Athens Area Health Plan Select, and One Health Plan of Georgia.

A review of the largest commercial payers with managed care plans suggests that movement in electronic medical records and pay-for-performance is in its infancy in Georgia. Several Georgia plans are reviewing options and developing initiatives to encourage physicians to move forward with electronic medical records. However, the levels of discussion and interest would suggest that progress could occur in the near term, particularly with outside pressures.

Blue Cross & Blue Shield Healthcare of Georgia (BCBSGA)¹

In 2004, BC/BS took the farsighted step of offering 4600 physicians in their network the option of selecting a free PC or a PDA for increased efficiency and better electronic management of their patients. For some physicians, this could have been their first PC to be used in this manner. The complimentary PC included their Clear Claim Connection software (see below) and other software to make it easier to check eligibility and to submit claims electronically. The PDA option was focused on electronic prescribing. The vast majority of physicians took advantage of the complimentary PC; only a handful (20-30) chose the PDA option.

The following are some of the electronic-based software and services being made available to BCBSGA network providers, as transition tools to encourage electronic practices.

- BCBSGA introduced the *Clear Claim Connection* (summer 2004), a new online product offered to network providers. This product was implemented with the cooperation of McKesson Corporation and enabled BCBSGA to share with providers the auditing rules and clinical rationale, which exist in the code auditing system.
- BCBSGA also released their new multi-Payor, HIPAA compliant desktop software product, *BlueConnect*TM. *BlueConnect*TM to be used for claim submission, claim status and eligibility. When all claims have been completed, they are transmitted for processing.

¹ Note, as reported at the November 17, 2006 meeting of the Health Information Technology and Transparency Advisory Board, BCBS has implemented new e-initiatives since the time of this survey.

The following is a “high-level” list of features for *BlueConnect*TM:

- Windows Functionality
 - Multi-Payor System, UB92 and HCFA 1500
 - Single or Multi-Payor
 - Import Mapping
 - Medical necessity edits, including CCI and LMRP
 - Claims triggered for 72-Hour Rule Conflict
 - Archive/Retrieval
 - Claims history retained (based on disk space available)
- BCBSGA is currently testing the Health Care Claim Payment (835 EFT) transaction and will be able to offer this capability soon. This means that electronic fund payments will be available to all contracted network providers. The 835 RA (Health Care Claim Remittance Advice) and the 835 EFT are two electronic transactions included within HIPAA’s Transactions and Code Sets Rule. Along with the 837 (Claim Submission) transactions, these can dramatically enhance business operations, while substantially reducing the time required to update accounts receivable and patient accounts.
- Below are some of the benefits BCBSGA has touted with receiving the 835 RA and 835 EFT:
- The time allotted to post payment to General Accounts will decrease dramatically.
 - Few payments will need to be handled manually.
 - Manual postings may be a thing of the past.
 - With the EFT, money will be available in your accounts faster.
 - With both transactions, the posting of payment and its deposit to the account will be in sync and will not require additional research to make sure that the money is in the account and reported for office records.
- BCBSGA can provide a regularly updated version of the BCBSHP HMO/POS formulary to be downloaded to a handheld Palm OS. The HMO/POS formulary is updated quarterly with the new downloadable version. In the near future, BCBSHP also plans to make this available for Pocket PC users.

In terms of pay-for-performance, a sister plan of BCBSGA, Anthem of Virginia has a pilot project that provides physician practices with credit and incentive payments for implementing an electronic medical records program. BCBSGA is reviewing this program and will consider it along with other options for future initiatives. BCBSGA can assist in identifying practices that may be interested in participating in the DOQ-IT program.

Kaiser Foundation Health Plan of Georgia (KP)

The Kaiser Permanente HealthConnect Program is a \$3 billion system-wide Kaiser Permanente initiative focused on using a common software system for all KP regions and facilities. (The total cost includes implementation and 10 years of maintenance and upgrades.) In addition to an electronic medical record, KP HealthConnect involves a highly sophisticated and nationwide information management and delivery system that includes every element of their health program; the clinical record along with appointments, registration and billing.

The KP HealthConnect program intends to improve the quality of health care provided across KP's national system. Patients, doctors, nurses and other authorized health care staff will have immediate access to complete, up-to-the-minute medical records. Those will include test and lab results, prescribed drugs, allergies and interactions and medical history. Through the new system, patients will also be able to schedule appointments, request medication refills and ask for referrals, and ultimately access their medical records and their doctors online from home.

This system links medical information with billing, scheduling, and registration data. Referrals to specialists can be made on-the-spot, prescriptions are sent to pharmacies electronically, and two doctors treating the same patient from different locations can share information in real time.

The KP HealthConnect Program specific function includes:

- Inpatient and outpatient clinical information and treatment guidelines for physicians
- Pharmacy operations
- Registration, scheduling of patients with providers and equipment
- Emergency and operating room access
- Online access for the member and health care providers
- Inpatient and outpatient billing

In Georgia, KP HealthConnect's clinical systems (inpatient and/or outpatient information available to Kaiser Permanente clinicians) will be in place for all 450 Georgia-based Permanente physicians by the end of 2005. Independent specialty physicians (approximately 200-300) are scheduled to be online with the system by 2006, with paperless systems. KP HealthConnect's online patient access systems will begin to be deployed in mid-2005.

KP does provide small (pay-for-performance) bonuses to selected specialties of Permanente physicians that are based on a formula of factors. These measures include certain quality measures (depending on the specialty) and the results of patient satisfaction surveys.

United Healthcare of Georgia

United is strongly encouraging physician offices to move toward electronic claims filing. In fall of 2004, United Healthcare contracted with HDM Corp. to offer a direct connection for providers to submit electronic claims. With the direct connection, providers who use HDM's electronic claims transaction software, Qwik+File(tm), can submit claims directly to United Healthcare for processing, producing a faster turnaround time on the claim, resulting in better service for the provider and the patient. Providers who use HDM's Qwik+File product can submit ANSI formatted claims, and the direct connection allows UnitedHealthcare to receive the electronic claims faster compared to traditional methods of claim submission.

United Healthcare Group has been involved and supportive of The Ambulatory Care Quality Alliance (the Alliance), a collaborative group consisting of physicians, purchasers, government, and other influential parties, who have recently announced the

implementation of new defining standards for physician performance assessment.

UnitedHealthcare has already begun integrating the consensus measures set forth by the Alliance into its physician quality performance activities. In fact, many of the measures are already fully incorporated into our existing measurement programs.

Specific measures adopted by the Alliance that were highlighted by United Healthcare (ostensibly as areas that they agree with and will also work on) include:

The consensus Ambulatory Care Quality Alliance performance measures, approved on April 28, 2005, include:

- Prevention measures such as breast, colorectal and cervical cancer screenings, and vaccinations against influenza and pneumonia
- Heart disease measures, including appropriate drug therapy for coronary artery disease, and heart failure management
- Diabetes management indicators such as HbA1C testing, and blood pressure and lipid control
- Asthma pharmacologic treatment
- Depression identification and appropriate medication management
- Evaluation of overuse and misuse of resources, such as the appropriate use of antibiotics in children with upper respiratory infections and pharyngitis .

Georgia is one of three locations (in addition to Illinois and St. Louis) established by United Healthcare as pilots for their practice rewards program, scheduled to be rolled out in early 2006. The program is based on evidence-based medicine with quality and efficiency scoring by specialty. Not all specialties have evidence-based criteria in place (for example, pediatrics); therefore, only certain specialties will be included in the program. In addition, physicians must have a critical mass of United's patient visits to have enough data in order to qualify to be part of the reward program. Finally, the contract arrangement relative to the payment schedule must be considered, which could also affect participation in the practice rewards program.

Basically, the physician can receive a small incentive over the standard payment schedule based on meeting certain quality and efficiency criteria. The Georgia plan is starting with independent, smaller physician groups rather than the bigger physician groups.

Electronic medical records are not required in order to participate in the program. The physician fee schedule must be based on a CMS fee schedule in order to participate.

Aetna Health

Aetna introduced an add-on program called Aexcel in January 2005, a preferred network that promotes access to certain specialists within the broad Aetna network for 12 high-cost specialty categories. Designated specialists have met certain standards for clinical performance and demonstrated efficiency in the care they deliver. These specialists also are eligible for incentive payments. Specialties currently included are:

- | | |
|--------------------------|-----------------------------|
| • Cardiology | • Obstetrics and Gynecology |
| • Cardiothoracic Surgery | • Orthopedics |
| • Gastroenterology | • Otolaryngology |
| • General Surgery | • Plastic Surgery |
| • Neurology | • Urology |
| • Neurosurgery | • Vascular Surgery |

Criteria for physician participation include:

- **Case Volume.** Specialists and groups currently participating in the network who have managed at least 20 Aetna cases over the last 2 years. A minimum volume of cases is necessary to meaningfully evaluate performance.
- **Clinical Performance.** Physicians who met the case volume threshold were then evaluated against established measures of clinical performance. General measures of clinical performance, as well as specialty-specific measures, were applied where possible. The specific clinical performance measures include:
 - A case-mix adjusted rate of unanticipated hospital readmissions within 30 days of discharge.
 - A case-mix adjusted rate of unexpected adverse health events experienced by a specialist's hospitalized patients.

For Example:

For cardiologists:

- 1) the rate of use of cholesterol-lowering medication in patients with cardiac disease.
- 2) the rate of use of beta blockers in patients with a history of an acute cardiac event.
- 3) the rate of ACE inhibitors use (or ARB) in patients with congestive heart failure.

For obstetricians/gynecologists:

- 1) the rate of cervical cancer screening.
- 2) the rate of breast cancer screening.
- 3) the rate of HIV testing in pregnant women.

The above measures are then compared to established thresholds determined by performance of the peer group. Specialists whose measured outcomes fall below the 5th percentile of the peer group are excluded from further consideration.

- **Efficiency.** Analyzed specialists' efficiency in treating members by applying Episode Treatment Groups (ETG) analysis using Episodes of Care (EOC) software, an illness classification system licensed from Symmetry Data Systems.

This risk-adjusted analytic tool looks at all of the services rendered in the treatment of an illness or condition, including ambulatory, inpatient, diagnostic imaging, laboratory, pharmacy and all other medical care incurred. For each specialist or specialty group, the adjusted cost per episode of care is derived. This value is then compared to the peer group of specialists by dividing the adjusted cost per episode by the regional average, adjusted for case-mix. All comparisons are made to the peer group of specialists in the region being analyzed.

- **Network Adequacy.** To account for local nuances in the health care system, such as the organization of specialty practices or the access needs of the projected membership, adjustments were made in each local market to allow for availability of specialty care. These considerations did not override the exclusion of a specialist on the basis of clinical performance.

Additional details concerning the methodology include:

Methodology used to define an Episode of Care.

Symmetry Health Data Systems® software and its Episode Treatment Groups™ (ETG™) methodology define episodes of care for analyzing performance. Physician, hospital, pharmacy and ancillary testing, as well as all other services related to an episode of care, are combined into a single case based on sophisticated algorithms that use procedure, diagnostic and other administrative information to assign the case to a particular ETG. Episode triggers and endpoints are defined in Symmetry's patented technology. The total cost of treating a particular episode of care is assigned to the managing specialist, and specialists are compared to the performance of their peer group based on the mix of episodes they treat and the total costs of care incurred for all of the episodes. The ETG methodology adjusts for the mix of episodes and the severity of disease present

Assigning claims/cases/episodes to a practice

Aetna licensed Symmetry's ETG Grouper methodology, which applies proprietary algorithms to assign relevant claims to specific episodes of care. The ETG Grouper considers each claim record based on the procedure and diagnosis codes submitted and assigns claims to an ETG. An algorithm is then applied to each episode to identify the managing specialist to whom the case is assigned. For example, in an episode primarily involving a surgical procedure, the logic identifies the surgical specialist managing the case. In an episode involving a medical condition, the logic looks for the physician who has seen the member most often.

Addressing severity and case-mix differences among specialists

Differences in patients' diagnoses, age, complicating conditions, co-morbidities and major surgeries have been factored into the definition of the ETGs. National and regional Aetna-specific ETG norms were created as comparison measures for each episode. These norms were adjusted for the specific ETG, patient demographics and geography (for example, age, gender, region and type of medical plan) and year

How often are physicians considered for designation

The performances of specialists in each Aexcel are assessed annually. In some circumstances specialists may be designated for a multi-year period.

Coventry Healthcare of Georgia (Coventry)

One of the smaller health plans was also contacted to find out if any of these activities were on the radar screen. Coventry has the largest market share of HMO enrollees of the smaller array of plans operating in Georgia. Coventry also has a managed care presence in several states.

Currently, Coventry has no initiatives or activities that would promote electronic medical records within physician offices other than encouraging physicians to submit claims electronically.

In terms of pay-for-performance, Dr. Cohen was aware that the company has a pilot project in Pennsylvania that incorporates pay-for-performance. The details have not been shared as yet. Also, if Coventry is awarded one of the Georgia Medicaid managed care contracts, the company would probably work with the state Medicaid program in developing a modest pay-for-performance program to support that contract.

D. Physicians

The Georgia Board for Physician Workforce has focused attention on the problem of Georgia's growing population with a stagnant and possibly declining number of physicians. That trend is expected to continue for a variety of reasons, including an aging physician workforce, high malpractice rates, and more women trying to balance work and home responsibilities.

There are approximately 15,500 physicians in Georgia. Of that total, about one-third are in primary care specialties with approximately 1700 in family practice, 2200 in internal medicine, and 1400 in pediatrics. While Georgia has fortunately seen an increase in primary care specialties over the last decade, geographic distribution of physicians remains an issue as practice site preference favors the urban areas of the state. The rate of physicians in the five core specialties (FP, IM, Ped, OBGyn, and Gen Surg) is considerably lower for non-metropolitan areas as compared to metropolitan areas. For example, the rate of pediatricians per 100,000 population is more than eight times greater in the metro areas. Some progress has been made in diversifying the physician workforce; the percentage of African-American physicians rose from 6.5% to nearly 12% and the proportion of those reporting to be "other" ethnicities increased more than four-fold since 1992.

Based on CMS registry data, Georgia has 1009 group practices. Fifty percent in the practice are primary care (GP, FM, IM). Georgia also has 1096 solo primary care solo practices. Somewhat surprising is that a third of Georgia's solo and group practices are in rural locations and about 2/3 in urban counties.

Georgia has four medical schools and eight community-based teaching hospitals. Teaching hospitals in Georgia range from hospitals with a single residency program to large academic medical centers sponsoring more than 50 residency programs. Research reveals that graduates tend to establish practice within a 50-mile radius of their residency program. If this is the case, of the 562 physicians graduating from a residency program in 2005, the majority will practice within one of Georgia's MSA.

Medical Association of Georgia

Medical Association of Georgia (MAG) has been engaged in developing an infrastructure to develop programs and initiatives to support physicians in the area of electronic medical records.

Initially, MAG surveyed their membership concerning their status and interest in electronic medical records. Based on that survey, it is estimated that about 5% of physicians have some type of electronic medical record system. It is estimated that well over half of practices have a practice management system. Based on MAG staff research,

the following EMR vendors are considered the most prominent in Georgia: GE, Misas, A4, Allscripts, Greenway, JMJ, Cerner, and NextGen.

MAG staff is not aware of any specific programs in the state that promote adoption and use of electronic clinical information. MAG has not conducted any programs as yet, but is developing a strategy, which includes the possibility of endorsing particular EMR vendors and developing its currently proposed e-technology education and training program. In preparation for potential endorsement of EMR vendors, MAG staff has been reviewing and comparing EMR vendor products and meeting with physicians who are using those products. In addition, the MAG Institute for Excellence in Medicine (a MAG subsidiary) has been involved in developing a plan for the multi-faceted education and training program for physicians and their staff. Funding for this program is currently being sought.

MAG staff is not aware of any pay-for-performance programs in Georgia at this time. However, there is interest in developing educational programs for physicians on pay-for-performance programs.

Medical Association of Georgia Institute for Excellence in Medicine

The Medical Association of Georgia established the Medical Association of Georgia Institute for Excellence in Medicine, Inc. (MAG Institute) in 2004, a not-for-profit subsidiary, focused on providing physicians with education and practical strategies to assist them in improving practice management and patient outcomes. The MAG Institute focuses on activities to support physicians, including educational programs and tools in addition to sponsoring applied studies to assess the effectiveness of practices and processes in the physician office.

One of the those strategies is the development of *the MAG E-Technology Academy*, which proposes to develop and implement educational activities and program opportunities focused on the clinical improvement of independent physician practices, designed to increase the knowledge base of physicians regarding the use of technology in their practice and to actively promote its use. The program of activities, which are planned for 2006-7, will target physicians statewide.

Medical Association of Atlanta

To date, Medical Association of Atlanta has not had any programs regarding electronic health or medical records. A few of their members have asked if MAA has any recommendations for EMR, but MAA has not taken steps in this direction. In terms of topics for educational programs, members seem to be more interested in HIPAA security and practice and risk management. Pay-for-performance has not surfaced as an issue for any of their programs. However, staff understands these topics are surfacing now and wants to be involved with upcoming initiatives, including the DOQ-IT initiative.

State Chapters of Medical Specialty Organizations

Georgia Academy of Family Physicians (GAFP)

The Georgia chapter of the American Academy for Family Physicians (AAFP) is closely aligned with their national chapters adopted policies. In April 2004, AAFP adopted a policy statement that includes promoting a model of health care delivery that “necessitates the use of health information technology (HIT) to improve quality, enhance patient safety, and increase efficiency. Electronic health record (EHR) software is viewed as the “central nervous system” of this New Model family practice.” The AAFP also established a Center for Health Information Technology, providing an array of resources for physicians.

The state chapter, GAFFP, has offered their own programs to member physicians since the fall of 2003. In March 2005, GAFFP presented a well-attended workshop, called “Electronic Health Record Blitz-A Hands-On Workshop”. This meeting was in conjunction with Board and Committee meetings. At this program, there were nine vendor workstations. Over 50 physicians moved through the vendor sessions, which were 30 minutes per session. When the bell rang, the physicians could move to another station. This program had excellent ratings from both vendors and physician attendees. At the annual GAFFP meeting in May 2005, EMR vendors are available for similar, extended sessions.

GAFFP has an endorsement agreement with one EMR vendor, Greenway. GAFFP is considering additional endorsement agreements.

GAFFP is not aware of specific pay-for-performance programs in Georgia, although they believe there are some. GAFFP is interested in providing programs to their members about pay-for-performance programs.

American College of Physicians, Georgia Chapter

The topic of electronic medical records is of vital interest to the ACP and the state chapter. To date, the national organization has focused attention and educational opportunities toward these topic areas. At the Georgia chapter level, the first initiative is in the planning stage for a two-part workshop dealing with EMR in March 2006. ACP-GA has not yet begun initiatives related to pay-for-performance, but this is another area of vital interest to the national ACP and to their chapter.

American Academy of Pediatrics, Georgia Chapter (AAP-GA)

The AAP-GA recently established a new committee called Clinical Information Technology, will focus attention on EMRs. The Committee will consider strategies, such as educational programs, endorsements, etc.

The AAP-GA has a committee, called Practice Management, that will be considering the topic of pay-for-performance. Educational programs for physicians are a possibility.

Georgia Osteopathic Medical Association

The not for profit Georgia Osteopathic Medical Association is not currently engaged in specific activities in support of EHR or in response to Medicare and commercial payor pay for performance programs.

Georgia Association of Primary Health Care Georgia EMR Project

This project will install Electronic Medical Records (EMR) at 13 member sites, train all clinical staff and develop disease tracking and reporting capabilities. Separate EMR software will be installed and standardized at the remaining members. A detailed continuing quality improvement procedure will be integrated. A pilot site has been selected for standardizing data elements and clinical flow. Following successful installation, the other selected site will be installed before moving to other members.

E. Multi-Stakeholder Health Care Policy/Quality Coalitions

Georgia has two active business coalitions focusing on health care issues. Georgia Healthcare Leadership Council represents a statewide association of major employers and pharmaceutical companies, developing and implementing quality and preventive-oriented strategies. Both the President and Chairman of this organization stated that they are very interested in promoting EMR and pay-for-performance programs and are willing to coordinate with others in this regard. In addition, the only other coalition, Savannah Business Group on Health, is active in this arena, having just implemented a pay-for-performance program for their members. Other emerging initiatives include a potential Bridges to Excellence project in Georgia, a fledgling Georgia Regional Health Information Organization (RHIO) that brought a group of interested parties together for the first time in mid-June, and an initiative of the Georgia Primary Care Association.

Savannah Business Group on Health

The Savannah Business Group on Health Care Cost Management, Inc, (SBG) was incorporated in 1982 and is comprised of regional business, industry and government. Since inception, SBG has focused on health care reform by introducing and implementing innovative cost saving concepts and value purchasing.

SBG is owned and governed by its members. Membership include: Atlantic Wood Industries, Bell Equipment, Bradley Dixie Companies, Brasseler U.S.A., Chatham County Government, Chatham Steel Corporation, City of Savannah, Colonial Oil Industries, Critz, Inc., Fuji Vegetable Oil, Georgia Ports Authority, Intermarine of Savannah, International Paper, Interstate Paper, McKenzie Truck Lines, Program Administrative Specialists, Inc., Savannah Electric & Power Company, Soft Sheen Carson, Sullivan's Administrative Managers, Sullivan's Staffing, SunTrust Bank, The Savannah Bank, and Yates Astro.

Effective June 1, 2005, SBG implemented a progressive pay-for-performance program in a first step in this arena. The intent of this new program is to provide financial incentives to physicians that meet the quality standards that are treating diabetes.

Through the SBG's Care Network with St. Joseph's/Candler, 54 physicians were identified that treat patients with diabetes. Using claims data, these physicians were evaluated using a formula. Based on 100 points, 40% are linked to clinical criteria; 20% to formulary criteria; 20% to IT usage and 20% to credentialing. The IT usage is dependent on the physician's usage of the hospital's information system: if the physician logs on for that patient, the physician gets full credit; if the staff logs, the physician gets

partial credit. Of the 54 physicians, 20 had at least 75 points of the 100 points. Therefore, these 20 physicians are now getting 20% extra reimbursement for each of their diabetes patients services.

SBG is also interested in promoting electronic record systems in physician offices and working with *gmc* and the DOQ-IT initiative. SBG believes that their initiatives have encouraged some physicians in the area to implement medical record systems in the last year.

The Georgia Project

The Center for Transformation is a Washington, DC-based organization, recognized as a change-agent for the structural underpinnings of the US health care system. Led by the Center's founder, Newt Gingrich is particularly focused on promoting electronic health records and pay-for-performance programs.

Gingrich has taken a leadership position in supporting electronic health records around the country. Gingrich is a frequent speaker at Georgia health care organizations and recently published this statement in the Atlanta Journal/Constitution, *"The electronic records will be used to reduce costly medication errors, detect fraud and enable the use of systems to evaluate health conditions and warn patients and doctors of impending dangerous and more expensive problems. An electronic record is particularly valuable for older Americans because they tend to have much more complicated health challenges than younger people. Proportionately, more mistakes can be avoided, more lives saved and more bad outcomes avoided among older Americans in an intelligent health system than would be the case with the same number of young people. Thus, Medicare is the right place to launch an electronic health record to get the maximum impact from President Bush's program for "saving both lives and money."*

The Center has developed their only state specific project in Georgia (Gingrich's home state). The State of Georgia Project is dedicated to creating a state model for the development of an intelligent health system that saves lives and saves money. Key strategies for the Georgia project include *moving to electronic systems, including electronic health records and e-prescribing*. The co-director of the Center's Electronic Health Record Project, Laura Linn, is located in Georgia and is also director of the Georgia Project, which has several components: 1) Diabetes Transformation, 2) Minority Health Project: Elimination of Disparities, 3) TriCounty Project, and 4) Medicaid Transformation. All of these initiatives are in the early development stages.

Diabetes Transformation: As the cornerstone of this effort, *Bridges to Excellence*, is establishing a project led by a coalition of Georgia's largest employers, focusing on diabetes transformation. The initial meetings with more than 50 employers, including UPS and Bellsouth, are scheduled for July 2005. Several employers are interested in participating in this Georgia project. The pharmaceutical company, Novo Nordisk, is a partner and supporter of this effort. Wellstar, a Georgia-based health system is also involved in the effort.

Minority Health Project: Elimination of Disparities: The Minority Health Project is being coordinated with Morehouse University School of Medicine and the National Minority

Health Month Foundation. Part of this project is developing a zip code, web-based program to assist in identifying and managing patients.

Regional Electronic Clinical Information Production and Use Initiatives (RHIOs)

The Southern Healthcare Administrative Regional Process Workgroup (SHARP), a public and private industry partnership, was conceived in 2000. This all volunteer workgroup's mission, which is supported through the individual efforts and outreach of its members is focused on assisting providers in Arkansas, Alabama, Florida, Georgia, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, South Carolina, Tennessee and Texas. SHARP Workgroup was striving to meet the needs of all regional stakeholders, by providing a collaborative regional health care and provider focus. This focus achieves implemented standards and furthers the development of implementation of future standards.

Their initial work centered around assessing the regional HIPAA Administrative Simplification implementation readiness to bring about regional coordination for successful HIPAA compliance by all stakeholders in the southern regional healthcare industry.

The Georgia Strategic Local Implementation Process (GSLIP) was a statewide group formed as a local response to the work of the SHARP Workgroup partnership. It consisted of more than 100 Georgia health care professionals, representing various sectors of the industry including Georgia health plans, hospitals, nursing homes, physician practices, various State of Georgia health agencies and technology firms.

The work of the GSLIP has recently moved from their HIPAA focus to that of helping to foster a Regional Health Information Organizations (RHIOs). The Georgia Health Information Exchange was formed in early 2006 and has continued to convene stakeholders in sharing information about the exchange of healthcare information to improve the quality, efficiency and transparency of healthcare information.

The following are examples of electronic networking that is underway in Georgia.

Tri-County Plus Rural Health Network (TCPRHN)

The Tri-County Plus Rural Health Network, once implemented will provide enhanced communication and bi-directional sharing of data and information necessary to improve care management, enhance admission/discharge planning, enhance patient safety and satisfaction, reduce the cost and inconvenience of redundant data development, and increase the efficiency and satisfaction of clinicians.

It will enhance the coordinated activity of committed stakeholders that is focused on their mutually agreed upon goals and responsibilities in the targeted rural, heavily minority and resource-poor communities.

West Georgia Health Information Exchange

The West Georgia HIE will allow for the electronic transmission of clinical data between the three Tanner hospitals and local physician offices. Over the course of a three-year

project period, the HIE will provide for the electronic transfer of patient demographic and insurance information, patient histories and physical information, lab and radiology orders and lab and radiology results. The system will also allow patients to access their medical records through the internet.

The West Georgia HIE will serve a predominantly rural portion of West Georgia and East Alabama. The area is comprised of seven counties. The area covers more than 2000 square miles and has a total population of more than 300,000.

OrderComm

Medical College of Georgia Health System

OrderComm is an order communication and management solution created by the MCGHI Information Systems Department (ISD) to electronically send orders from patient care areas and clinics to the appropriate hospital-based services via a scanner. The main goal of this project is to improve patient safety. MCG Health System is implementing OrderComm because currently this is not consistent method of communicating orders (sent by fax, pneumatic tube, phone, by foot, etc.), there is no verification that the order has been received by the service or that it is being processed. It is a manual process, time intensive, people intensive and there is a long time between writing the order and the actual processing and completing of the order. OrderComm allows the health system to accomplish many things. It standardizes order communication and documentation. It reduces errors and improves patient safety. It minimizes variance in practice patterns....it improves efficiency. It is user friendly and meets the JCAHO standards of care.

Georgia EMR

Georgia Association for Primary Health Care

This project will install Electronic Medical Records (EMR) at 13 member sites, train all clinical staff and develop disease tracking and reporting capabilities. Separate EMR software will be installed and standardized at the remaining members. A detailed continuing quality improvement procedure will be integrated. A pilot site has been selected for standardizing data elements and clinical flow. Following successful installation, the other site will be installed before moving to other members.

Pharmacy Services

The Georgia Pharmacy Association (GPA) represents 2500 pharmacists, 700 of which are with independent pharmacies. GPA has been advocating for electronic prescribing in Georgia. Pharmacists are concerned about all of the different EMR systems used by physicians and the problems of interconnectivity. A bill was passed to authorize electronic prescribing; however, there is a glitch in the bill that prevents a third party to translate the data from the various EMR systems. Therefore, electronic prescribing has not really moved forward in Georgia.

GPA recently met with the Georgia Association of Family Practice to begin to work out issues that would promote electronic prescribing. A major GPA concern is the numbers and differences in EMR software systems.

AHRQ Grants in Georgia Related to Health Information Technology or Pay for Performance

Comprehensive IT Solution for Quality and Patient Safety

Children's Healthcare of Atlanta is in the process of implementing a series of new health information technologies to improve patient safety and quality as well as increase efficiency of all operations. Four related technologies, focusing on pharmacy, will be implemented in a carefully staged process over the next two years: 1. Inpatient Pharmacy System, 2. Electronic Medication Administration Record, 3. Bar Coding System, and 4. Computerized Provider Order Entry System. This pediatric health system has partnered with three unique organizations to implement and evaluate the impact of the technologies and the staged approach on safety, quality and efficiency: Epic Systems Corporation, which supplies the technology solutions; the Health Systems Research Center and the Laboratory for Human Computer Interaction and Health Care Informatics at Georgia Tech; and the Emory Center on Health Outcomes and Quality at Emory University. Georgia Tech and Emory will together provide the research and evaluation expertise needed to fully document and evaluate the HIT implementation as well as derive general recommendations for optimal HIT implementation creating maximum benefit in terms of quality, safety, and efficiency.

The Agency for Healthcare Research and Quality has funded this initiative for an estimated total of \$1,495,572 with year 1 funding of \$499,208. The project start date is September 30, 2004 and the project end date is September 30, 2007.

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